

Equity in health and health care:

a WHO/SIDA initiative



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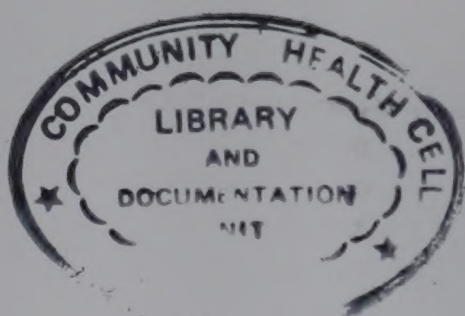


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Foreword

One of the cornerstones of the primary health care (PHC) principles, defined at the Alma-Ata conference in 1978, is to improve equity in access to health and health care.

The gradual improvement in health worldwide, as measured in life expectancy and accompanying reductions in preventable deaths, conceals growing differences among people and countries. The "health gap" between the most fortunate group and the poorest and sickest is widening in rich, transitional and poor countries.

This booklet acknowledges failure in this aspect of PHC and calls for action to prevent these disparities from growing still further and to ensure that the most disadvantaged groups and countries enjoy a fair share of the next decade's health gains. Several avenues must be followed.

Firstly, there is a need to assess and monitor at local level how health outcomes vary among different subgroups of the population. Ethnicity, gender, occupation, income and age are important factors in differential access to care and health outcomes. While health care is only one contributor to health, it can make a life or death difference, and its equitable availability is a measure of the value a society places on social cohesion and solidarity.

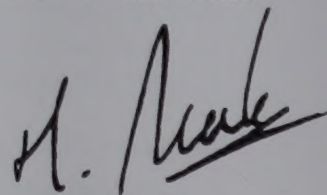
Secondly, the hand of health policy-makers must be strengthened, so that hazards can be anticipated, achievements from elsewhere tried out, and evidence produced to show that inequity is often unnecessary and debilitating.

And thirdly, concern must be voiced by individuals and agencies who can influence policy decisions. Equity has lost prominence in the agenda in the currently prevailing orientation of economic and social policy, in which individual responsibility and market mechanisms have been emphasized.

Besides leading work related to health services, the health sector has a responsibility to promote and collaborate with other sectors in action to reduce health inequalities.

Access to health is everybody's right; the ethical basis of health policy remains Health for All, and inequity is both unacceptable and avoidable. Our challenge for the next decade is to tackle inequity and mobilize support for a rebirth of health for all.

We hope this booklet will be a useful tool for enhancing the work of different health partners in this task.



Hiroshi Nakajima, M.D., Ph.D.
Director-General
World Health Organization

Executive summary

What is equity in health and in health care?

Equity means that people's needs, rather than their social privileges, guide the distribution of opportunities for well-being. In virtually every society in the world, social privilege is reflected by differences in socioeconomic status, gender, geographical location, ethnic/religious differences and age; other dimensions also can be very important. Pursuing equity in health and in health care means trying to reduce avoidable gaps in health status and health services between groups with different levels of social privilege.

The WHO initiative for equity in health and health care

Wide and widening gaps in health and health care between different social groups exist throughout the world, even in countries where aggregated data suggest overall progress. The World Health Organization (WHO) has embarked on a global initiative whose goal is *to promote and support practical policies and action to reduce avoidable social gaps in health and health care*. The initiative builds on work towards health for all by WHO and others over the past three decades, but is based on a critical reassessment of needs and strategies in light of current economic, social and political conditions prevailing throughout the world as we approach the year 2000. The WHO effort responds to concerns shared by other organizations and specialized agencies of the United Nations system, including UNDP and UNICEF.

WHO and the Swedish International Development Cooperation Agency (SIDA) have funded initial planning and development; previous efforts by WHO in Western Europe and other regions have provided a foundation. Projects are now under way in one country in Africa and one Asian country, conducted by domestic governmental and nongovernmental organizations with technical assistance from WHO. Nongovernmental and governmental organizations in several additional countries, including both industrialized and developing nations, have expressed interest in participating. In addition, current and prospective participants from different countries have expressed a need for opportunities to exchange international experiences and strategies most likely to be effective under current conditions of severe resource constraints on social spending. It is recognized that long-lasting action to decrease inequities depends on decisions by international agencies as well as by countries. Additional sources of support are needed to expand and further develop the initiative, linking it with complementary efforts.

The objectives of the WHO initiative are:

- to make the reduction of social gaps in health and health care a higher priority on the agendas for policy and action of national and international organizations, recognizing the pressures created by current economic, social and political trends.
- in selected countries, to support targeted research and ongoing monitoring activities needed to develop and evaluate effective and efficient policies to reduce social gaps in health and health care. The activities in selected countries should develop models and technical instruments that other countries may adapt for their own conditions.
- to promote and support international exchange of experiences likely to be effective and efficient in reducing social gaps in health and health care.

The background

Gaps in health status and health care among different social groups are unacceptably wide both in many developing countries and industrialized countries. Inequities are widening in many nations, accompanying changes in overall economic policies – with or without changes in health care policies.

Traditional means of assessing health and health care often hide large or growing disparities between groups, because the data are either unavailable or are examined only as overall averages.

Health action has often neglected issues other than health care, missing opportunities for greater equity, effectiveness and efficiency. Social gaps in health show the need to reassess social and economic policies overall, not only health care policies.

Equity in health and health care must be placed higher on the policy agenda in the current political and economic climate; long-term effectiveness and efficiency are also essential.

The global economic recession of the 1980s, along with structural adjustment programmes in developing countries and cost containment pressures in industrialized nations, has resulted in reduced social spending in many countries.

Countries are finding it difficult to implement equitable policies and often feel caught between considerations of equity and of short-term efficiency. There is insufficient consensus on the most practical means of measuring or reducing social gaps in health and health care under current conditions of resource constraints.

Because of these problems, concerns about equity must be made more explicit and more public. There are both ethical and pragmatic arguments for equity; effectiveness and efficiency are practical imperatives. The goal is a fair sharing of progress for all,

not an equal distribution of deprivation. There is a need for both systematic study and public discussion of equity and how it can be achieved effectively and efficiently. Reliable information from high-quality, policy-oriented research and ongoing monitoring is needed to stimulate discussion, develop sound policies and guide implementation.

From information to action

Improvements are needed in ongoing monitoring of equity in health and health care over time; targeted research is needed to develop and evaluate strategies to reduce social gaps in health and health care effectively and efficiently. However, most countries – rich or poor – already have extensive, underused data that could be useful. Often what is lacking is thoughtful analysis and clear presentation in nontechnical terms relevant to the concerns of the target audience.

Better information is needed, but information by itself won't produce effective action. Public awareness and consensus must be mobilized to ensure political will. Political obstacles to equity, effectiveness and efficiency must be addressed strategically. Donor actions must support more equitable policies.

Because overall economic and social influences are powerful – often the most powerful – determinants of health, intersectoral action is essential to achieving effective and efficient changes.

People are already taking action locally and nationally in many countries to achieve more equity effectively and efficiently, even under adverse conditions. Promising experiences and strategies must be shared widely and discussed.

Part 1

Why has WHO launched an initiative for equity in health and in health care?

Social gaps in health and in health care are unacceptably wide and are widening throughout the world, both in developing countries and industrialized countries. Routine information often hides these gaps or fails to result in effective action to diminish them. Social spending is being constrained by many powerful pressures. Countries are finding it difficult to implement equitable policies and often feel caught between considerations of equity and short-term efficiency.

Equity, long-term effectiveness and efficiency are all essential. Equity in health and health care must be placed higher on the public policy agenda. Promising practical approaches to achieving equity in health development that are already under way must be assessed, shared and replicated even as new approaches are developed and all experiences are evaluated critically.

The World Health Organization (WHO), with seed funds from the Swedish International Development Cooperation Agency (SIDA), has launched an initiative to address these issues. The WHO initiative builds on three decades of work by WHO towards health for all and arises from concerns shared by other United Nations organizations and specialized agencies, including the United Nations Development Programme (UNDP) and the United Nations Children's Fund (UNICEF).

This document was written to explain the WHO initiative and to rally broad support for it and for linked and independent efforts by others, both within countries and in international organizations. It begins with an explanation of why WHO and SIDA have undertaken this effort, in light of recent economic and political trends that have made it increasingly challenging for many countries to implement equitable policies. The second section explores key concepts, presenting operational definitions of equity and of equity in health and health care and diverse arguments for the importance of equity in health and health care. The third section gives an overview of the objectives, strategies and current activities of the initiative. The final section appeals to national and international organizations in both the public and private sectors to undertake discussions and actions designed to lead to greater equity in health and health care.

- Social gaps in health and health care are unacceptably wide in developing and industrialized countries alike.
- Inequities are increasing in many countries. Countries are finding it difficult to implement and sustain equitable policies.
- Routine information often hides the gaps or fails to result in effective action.
- Social spending is being limited by many pressures.
- For all these reasons, equity in health and health care must be placed higher on the policy agenda; effectiveness and efficiency are also essential.

Social gaps in health and health care are unacceptably wide in both developing and industrialized countries.

For many years, routine population statistics have shown striking differences in health between richer and poorer nations. Overall, a child born in a developing country of Africa, Asia, or Latin America is roughly ten times more likely to die before reaching age five than a child born in Europe or North America (United Nations Children's Fund, 1991).

Less information has been routinely available on the gaps between better- and worse-off groups within countries. In virtually every society in the world, social privilege is reflected by differences in socioeconomic status, geographical location, gender, racial/ethnic differences and age; other dimensions can be very important as well.

Gaps between socioeconomic groups. The life expectancy at birth of the most disadvantaged segment of the population in Mexico is 20 years less than that of the most affluent segment (United Nations Development Programme, 1991). Adults in Sao Paulo, Brazil, in the late 1980s had death rates that were two to three times higher if they worked in nonprofessional versus professional jobs (World Bank, 1993). In Bolivia, most public spending on health goes towards care for people belonging to the upper two income quintiles, although these groups already have the best health status (Unidad de Analises de Politicas Sociales, 1993).

Gaps between geographical groups. In Nigeria, the average life expectancy in one region, Borno, is only 40 years (18 years less than in the Bendel region) and adult literacy (12%) is one-quarter of the national average (United Nations Development Programme, 1994). Although only 39% of the population of Côte d'Ivoire lives in cities, cities receive at least 80% of the public health expenditure (Vogel, 1988). In Peru, the infant mortality rate in Lima is 50 per 1000 live births, while in some rural areas it is as high as 150 per 1000 (Pan American Sanitary Bureau/Economic Commission for Latin America and the Caribbean, 1994).



Gender gaps in health often are due to differential treatment, not biological differences.

Photo: UNICEF/John Balcomb (ICEF 6753/73)

Gender gaps in health. A study in India showed that female infants 1 to 23 months of age were almost twice as likely to die by the age of two as were males, and concluded that the most likely explanation was different behaviour of families towards male and female children, not biological differences (Das Gupta, 1987). A UNFPA report concluded that the death of one out of every six female infants in India, Bangladesh and Pakistan was due to neglect and discrimination (United Nations Population Fund, 1989). Studies in Bangladesh found that boys under five years of age were given 16% more food than girls the same age (United Nations, 1993).

Gaps between racial/ethnic groups. In Guatemala, poverty is much higher among indigenous people; malnutrition rates during the 1980s were 40% higher among indigenous children compared with non-indigenous children (Psacharopoulos et al., 1993). As of 1990, death rates for non-white men in South Africa were double those of men of European background in the same country (Yach & Harrison, 1995). More than four times as much money was spent on health care for whites as for blacks in South Africa (ibid.).

Gaps between age groups. In the United States of America in 1994, 22% of the children lived below the poverty level, compared with 12% of non-elderly adults (U.S. Bureau of the Census, 1995). The U.S. Medicaid programme was designed to ensure health care to disadvantaged children and their mothers, while Medicare was to ensure health care for the elderly regardless of income. Not only is Medicare far better funded than Medicaid, but more than two-thirds of Medicaid funds go for care for the elderly and for disabled adults (Kaiser Commission on the Future of Medicaid, 1995; Oberg & Polich, 1988).

Recently inequity has been worsening in many countries. Countries are finding it difficult to implement and sustain equitable policies.

Information on trends in health and health care over time is limited, especially in developing countries. However, a growing body of evidence is accumulating from many sources, including the World Bank and other members of the United Nations system, indicating widening gaps or, where data on gaps over time are unavailable, worsening health conditions among the disadvantaged or even overall; in some cases, information is lacking on the health impact but widening social inequalities are well documented.

Widening health gaps or worsening conditions have accompanied changes in overall economic policies or conditions – with or without changes in health care policies. The 1996 UNDP *Human development report* notes widening income inequalities in many countries, including Argentina, Australia, Bangladesh, Bolivia, Brazil, Bulgaria, the Czech Republic, Estonia, Latvia, Lithuania, Peru, Thailand, the United Kingdom, the United States of America (USA), and Venezuela (United Nations Development Programme, 1996a).

Widening health gaps in industrialized countries. The *Black report* on social inequalities in health in England showed that gaps in death rates between employed men who worked in the highest and lowest socioeconomic status jobs widened consistently during the period 1949 to 1970; in addition to the gaps among groups increasing in size, death rates of unskilled workers in certain age groups rose in absolute terms



Political changes have resulted in worsening overall health statistics in some countries.

Photo: UNICEF/Danielle Maillefer (95-0369)

during the 1960s (Gray, 1982) and 1970s (Marmot & McDowall, 1986; Harding, 1995). This accompanied widening income inequalities and occurred despite a serious commitment to equity by the National Health Service (NHS) (Smith, Bartley & Blane, 1990).

Income inequalities have widened markedly over time in the United States (United Nations Development Programme, 1996a; U.S. Bureau of the Census, 1996). Routine health data in the USA have been monitored by race, but not by socioeconomic status; "the Black/White disparity in infant mortality has not only persisted but increased over time" (Singh & Yu, 1995). The proportion of all deaths among adults in the USA – among both whites and blacks – that are likely to be due to poverty "increased in recent decades" (Hahn et al., 1995). The relationship between socioeconomic status and death rates has become stronger between 1960 and 1986 in the USA (Pappas et al., 1993). Comparable observations have been made in other industrialized countries (ibid.).

Worsening overall health statistics in some countries where social inequalities have widened. Political changes in Russia and throughout Eastern Europe have had profound health consequences that are revealed even in national averages, without any disag-

gregation by social group; it is known that the least-advantaged social groups are experiencing the major impact. Men's average life expectancy has fallen from 62 to 59 years in Russia since 1992 and is still falling. Overall, the mortality rate in Russia "has risen by 20%, an increase with no modern precedent." Between 1993 and 1994, death rates due to infectious diseases rose by 17.9%. This included rises in cases of diphtheria (by almost 400%), measles (over 400%), typhoid fever (300%) and whooping cough (over 150%), all of which are preventable with basic, low-cost public health measures (Specter, 1995; World Health Organization Regional Office for Europe, 1994; World Health Organization, 1995c).

Alarming trends are being seen in countries that have historically put a high priority on equity. According to Birdsall and Hecht (1995): "In the 1960s and 1970s, China experienced one of the most dramatic advances in health of any developing country: child mortality, for example, declined from 210 to 85 per 1000 live births between 1960 and 1975. Much of this progress was due to broad-based provision of public health services in . . . insect vector control, immunization, improved hygiene, and family planning", backed by well-targeted public spending. At the same time, China's unique rural health insurance system, which covered about 500 million persons in the 1970s, guaranteed adequate funding for basic clinical services (e.g. treatment of tuberculosis and respiratory infections and safe pregnancy and delivery care) throughout the country.

As an unfortunate consequence of China's liberalization programme of the past decade, government funding for public health has declined and the rural insurance system has now largely disintegrated. A recent study suggests that these new health policies have made the distribution of government spending for health in China more unequal and may be contributing to an increased incidence of easily treatable diseases such as tuberculosis (Birdsall & Hecht, 1995).

Structural adjustment has been widely associated with deterioration in conditions for vulnerable groups. Economic "structural adjustment" programmes in developing countries, generally mandated by external donor agencies in response to economic crises, have resulted in cuts in social spending and privatization of formerly public functions. In Zambia between 1980 and 1984 – the height of implementation of that country's structural adjustment programme – hospital deaths due to malnutrition rose from 2.4% to 5.7% of infants under one year of age and from 38.0% to 62.2% of children aged one to four (Kanji & Manji, 1991). Similarly, in Nigeria, low-birth-weight rates almost doubled (from 7% to 13%) at a major hospital from 1984 to 1989 (Ibe, 1993). There is evidence that women suffer more from structural adjustment programmes than do men (Kanji & Manji, 1991; Jazairy, Alamgir & Panuccio, 1993).

Cost recovery in the health sector (versus obtaining revenues for health services from general, progressive taxation) may be inherently inequitable as well as inefficient. As part of structural adjustment, many governments have implemented cost-sharing mechanisms such as user fees to help finance health services. User fees overall have proven to be very difficult to implement except in very protected circumstances, without letting the most vulnerable people suffer. Reinvesting user fees in improved quality of local services has proven an elusive goal (Creese, 1990). The costs of determining eligibility for fee waivers often exceed the returns in fees collected.

In Zimbabwe, use of recommended maternal and child health services decreased by 30% after intensified enforcement of user charges in 1991 (Hongoro & Chandiwana, 1993). When user fees were implemented in Swaziland, there was a marked decline in use of basic health services among patients previously exempted for poverty (Yoder, 1989). A study in the Volta Region of Ghana found that after the establishment of user fees in 1985, use of basic services in rural areas fell substantially and did not subsequently recover (McPake, 1993); such services are likely to have been primarily for essential, prevention-oriented care.

Economic recession and weak economic performance also threaten equity. In the early 1980s, many countries experienced severe economic recessions that had significant adverse and well-documented effects on vulnerable populations, particularly children.

Malnutrition and infant and child death rates rose from the late 1970s to the early 1980s in Ghana, a country hard-hit by economic recession and drought (Cornia, Jolly & Stewart, 1987). In a UNICEF study of the effects of the recession, eight of the ten countries studied showed a deterioration in the nutritional status of children and many also showed an increase in child and infant mortality rates (*ibid*).

Despite being a very poor country, Sri Lanka has had remarkably low rates of infant and child mortality; this achievement has been attributed to a long-standing tradition of social investment and efforts at poverty alleviation. Since the 1960s, falling export prices, increased oil prices, drought and ethnic conflict have all contributed to an economic crisis that has led to cuts in health and education expenditures as well as food subsidies. Poverty and child malnutrition rates are unacceptably high. (United Nations Children's Fund, 1995).

Routine information often hides the gaps or fails to result in effective action.

Traditional means of assessment of health and health care often hide large or growing disparities between groups or fail to lead to corrective action even when disparities are revealed. Developing countries often have limited data. Even in more prosperous

countries, routine methods of analysing and presenting data as nationwide, provincial, or city-wide averages obscure large gaps between diverse groups within territories. The policy implications of health disparities – not only within the health care sector but in all sectors influencing health – are rarely made clear enough in ways useful for busy decision-makers.

Routine data are rarely separated according to socioeconomic status. However, in the Punjab region of India the infant mortality rate among landless people in rural areas is 36% higher than among landholders (United Nations Development Programme, 1991). In Venezuela, more disadvantaged municipalities have infant mortality rates three times higher than more prosperous municipalities (Pan American Sanitary Bureau/United Nations Economic Commission for Latin America and the Caribbean, 1994), a disparity that would not be revealed by regional or simple urban/rural comparisons. Sao Paulo, the largest city in Brazil, has relatively better health statistics than many parts of the country and infant mortality rates have been declining over the past decade. However, an infant living in the city's most impoverished district is more than three times more likely to die during the first year of life than an infant living in the city's wealthier zone (Cohn, 1992).

In Salvador, Brazil, a study found that while less than 4% of all deaths in the city's highest-income zone were among infants, more than half (52%) of the persons who died in the most impoverished zone were infants (Paim et al., 1987). In Indonesia in 1990, only 12% of public spending for health was for services consumed by the most disadvantaged 20% of households, who would be expected to need more health services because of poverty; the wealthiest 20% consumed 29% of the government subsidy in the health sector, despite having better health status and private resources (World Bank, 1993).

Experiences in countries with generally superior data on socioeconomic inequalities in health have suggested that even extensive and clear information revealing avoidable social inequalities in health may not lead to effective policy responses. Getting from information to action requires mobilizing broad public awareness of the problem and consensus on directions for solutions. Political forces must be addressed, and strong linkages are needed between the different sectors that influence health. Sustained effort is needed.

Social spending is being constrained by many powerful pressures, both economic and political.

The World Health Organization's 1978 Declaration of Alma-Ata on primary health care voiced an international commitment to focusing on effective and efficient ways to ensure the well-being of all; that commitment to equity crystallized during a period

of widespread economic growth. During the 1980s and since, however, economic recession has been experienced virtually worldwide, along with the economic and political effects of globalization of the world's economy.

Structural adjustment programmes in developing countries and moves to increase competitiveness in industrialized countries have led to diminished social spending. Increasing military spending has devoured resources potentially available for social development. In many countries the economy has shifted from being centrally planned and regulated to being market-dominated to varying degrees.

In many countries there has been a questioning of the role that governments should play, and a marked trend towards privatization of many functions formerly within the public domain. There has been an increased awareness of the fragility of environmental resources. For many reasons, there has been an increasing recognition of the need for more productive use of available resources in both rich and poor nations.

A heightened awareness of the need for greater efficiency and effectiveness has coincided with an array of other powerful pressures to constrain social spending. The unfortunate result appears to be a shift in social values away from ensuring the good of all towards increasing immediate economic opportunities for some, generally benefiting those socially positioned to profit most and most rapidly.

The justification for this approach has been that only by placing first priority on efficiency and overall economic growth can societies break out of the vicious cycle of poverty and underdevelopment. The reasoning is that when adequate rates of growth are achieved, the benefits will trickle down to all; the idea is that too much emphasis on equity now will jeopardize economic growth and perpetuate poverty and deprivation.

This line of thinking is not necessarily expressed so bluntly, or even expressed at all; nevertheless, it is a powerful force shaping the policies that shape people's health. Considerable evidence has accumulated to discredit this approach (see section 3, under "Strategies under consideration").

Equity in health and health care must be placed higher on the public policy agenda; long-term effectiveness and efficiency are also essential.

For all the reasons discussed above, equity in health and in health care must be placed higher on the policy agenda; equity, effectiveness and efficiency are all essential. Promising practical approaches to achieving equity in health development that are already under way must be assessed, shared and replicated, even as new approaches are developed and all experiences are evaluated critically.

Part 2

Definitions and basic concepts

- Equity means that people's needs guide the distribution of opportunities for well-being.
- Equity requires reducing unfair disparities as well as meeting acceptable standards for everyone.
- Pursuing equity in health and health care development means trying to reduce unfair and unnecessary social gaps in health and health care, while working efficiently to achieve the greatest improvements for all.
- There are both ethical and pragmatic arguments for equity in health and health care.
- Equity in health care requires equity (a) in the way health care resources are allocated, (b) in the way health services are actually received, and (c) in the way health services are paid for.
- This initiative is concerned with avoidable gaps in health status as well as in health care. Widening gaps in health status may be one of the most sensitive indicators of problems with broad economic or social policy; responses by the health care sector alone may not be effective or efficient.

What is equity?

Equity means fairness. It means that people's needs, rather than social privileges, guide the distribution of opportunities for well-being. In virtually every society in the world, differences in socioeconomic status, gender, geographical location, ethnic/religious group and age reflect differences in social privilege that heavily influence opportunities for health and well-being; other dimensions can be very important as well.

Whitehead (1990) has noted that "the term 'inequity' has a moral and ethical dimension. It refers to differences which are *unnecessary* and *avoidable*, but in addition are considered *unfair*, and *unjust*." What is avoidable will vary with potentially available



Equity means reducing unfair disparities as well as meeting acceptable standards for all.

Photo: UNICEF/Maggie Murray-Lee (4415DZ/90)

resources; people may disagree about what resources are potentially available at a given time. And notions of what is fair or just may vary among different societies. Each society must achieve a sufficient level of consensus about what equity means for that society in order to take effective action to reduce inequities.

Reducing unfair disparities as well as meeting acceptable standards. For some, a commitment to “equity” means that all social groups should have a basic minimum level of well-being and services, but that it is acceptable for some social groups to have better health or health care than others, so long as government does not pay directly or indirectly for the additional benefits.

There may be substantial disagreement about what constitutes a “minimum” level in health and health care. Conclusions are quite different if “minimum” standards mean very good standards, or if “minimum” standards ensure only that no one starves to death when food is available nearby or bleeds to death for lack of timely emergency care after an accident.

Pursuing equity in development means trying to eliminate disparities in well-being as all groups are brought up to a high standard. In many settings during the foreseeable future, reducing inequity involves first achieving minimum basic services for more and more people, but this is an intermediate target rather than a final objective.

The gaps matter in themselves, not only the absolute levels of well-being. Evidence is accumulating in industrialized countries that in addition to a group's absolute level of poverty, socioeconomic position relative to other groups also makes a significant difference in health. Studies have shown strong correlations between the size of income gaps in a number of countries and states within countries, and the health of their populations, that are not explained by the absolute levels of income (Wilkinson, 1992; Kaplan et al., 1996; Kennedy, Kawachi & Prothrow-Stith, 1996). Living in an inequitable society could harm health through many economic, social, psychological and physiological pathways (Adler et al., 1994; Kaplan et al., 1996).

What is equity in health and in health care?

Pursuing equity in health and in health care means trying to reduce unnecessary social gaps in health and health care while working efficiently to achieve the greatest improvements for all. It requires a commitment to push for the achievement of the highest possible standard of health that can be shared by all.

"Good health is, by definition, an integral part of social development . . . (World Health Organization, 1995a).

Levelling up rather than levelling down. Whitehead (1994) has discussed the need to "level up" rather than to "level down." Pursuing equity in development means moving towards high standards for all, bringing everyone up to the greatest common denominator, rather than trying to lower the previously privileged to the least common denominator. Csaszi (1990) comments that "in reviewing the Hungarian situation it is said that the ideals of a higher living standard and economic security have a much broader appeal in public opinion than equality."

The World Health Organization has defined the attainment of the highest possible level of health – i.e. "physical, mental and social well-being and not merely the absence of disease or infirmity" – as a fundamental human right (World Health Organization, 1990).

Pursuing equity in health and health care rests on a commitment to equal opportunity for all to attain the highest possible level of health.

Equity in sharing progress, not an equal distribution of poverty. Whether poor or affluent, any country that has neglected concerns about productivity and quality has realized, at least by the early 1990s, that this is untenable, at least politically. Populations continue to grow, and population expectations regarding quality of life and access to goods and services also continue to grow. People's material expectations are fed by global communications that now permit disadvantaged rural and urban families in India or Brazil to know about the lifestyles enjoyed by wealthy families in India or Brazil or by both wealthy and less well-off families in France, Sweden or the USA.

Failure to attend to productivity and quality can lead to continuing or increasing poverty, which is not consistent with health development. Equity in development means a fair sharing of progress, not an equitable distribution of avoidable misery and deprivation.

Globalization of the economy has pushed affluent countries such as the USA and European nations to take measures to increase efficiency, in order to compete with each other and with developing countries of the Americas and Asia as sites for production of goods. Many countries are reviewing and reforming their policies in the hope of containing costs and improving accountability and service quality in the health sector.

Greater attention to efficiency, productivity and quality is a critically important advance. Resources must be used wisely; waste is unfair to all, but will probably take the heaviest toll on the most vulnerable members of a society. However, especially in countries moving from planned to market-oriented economies, there is a real risk that concerns about equity can be forgotten – or paid token attention – on the policy agenda.

The primary health care strategy articulated and promoted by WHO from the late 1970s onwards was specifically designed to achieve equity along with effectiveness and efficiency in settings with severe resource constraints. This strategy is at least as relevant today as it was 20 years ago, when there was perhaps a higher expectation of growing rather than shrinking resources for social investment.

Why is equity in health and health care important?

Disregard for equity in health and health care means disregard for guaranteeing equal opportunity to all to attain the highest possible level of health. Disregard for equity means accepting that some people, solely because of being disadvantaged in society, will experience unnecessary suffering, physical disability or limited mental development, or will die before their time.

Some have argued for equity on pragmatic rather than ethical grounds. Political arguments for equity include the following: If segments of a society are excluded from benefits enjoyed by others, the excluded groups become discontent and can threaten the well-being of the more privileged groups via organized or spontaneous violence. When he was head of the World Bank, Robert S. McNamara stated that the "pursuit of growth and financial adjustment without a reasonable concern for equity is ultimately socially destabilizing." (World Health Organization, 1995b).

Arguments for equity in health and health care must be based on achieving long-term economic capacity and real productivity, which must be distinguished from short-term efficiencies. At times, the most rapid way to observe advances in aggregated indicators of growth may be to give more to those who already have the most and need the least, because they are often best equipped to be immediately productive with a given additional input. But this will leave those in greater need behind, limiting the capacity for long-term development of the society as a whole. Short-term and unsustainable efficiency gains are often used to justify inequitable decisions. Short-term gains are more easily measurable than long-term progress.

Short-term efficiency must be distinguished from long-term productivity. Societies cannot afford to discard their human capital.

Malnutrition and poor health decrease worker productivity (Cornia, Jolly & Stewart, 1987; World Bank, 1993). Education of girls and women is associated with improved nutrition, decreased infant mortality and decreased fertility (Cornia, Jolly & Stewart, 1987). In Peru, children of uneducated mothers are only one-third as likely to be fully immunized as the children of women with a secondary-school education (World Bank, 1993). Promoting women's education not only improves the health of their children, but also leads to greater employment possibilities for women.

Throughout the world, when primary care services of adequate perceived quality and convenience are not available relatively close to people's homes or workplaces, people seek primary care services at sites that are more costly because they are centres for

secondary and tertiary care (e.g. hospital emergency rooms and specialty-oriented outpatient clinics).

F. Zumbado, UNDP's Regional Director for Latin America and the Caribbean, recently said: "In our part of the world there is a consensus that reducing social inequity is not only an ethical, but also a political and economic imperative. Equity is good business" (United Nations Development Programme, 1996b).

Arguments for equity in health and health care based on the self-interest of more privileged groups, who want to avoid spillover effects of poor health among the disadvantaged, include the following: Inadequate spending on public health measures such as immunizations and control of highly infectious diseases among high-risk groups leads to catastrophic short-term and long-term costs that, on economic grounds alone, may far outweigh the investment necessary for prevention. Neglect of tuberculosis control ultimately jeopardizes the health of the more affluent as well as of the less well-off who provide services for them in their homes, shops, restaurants and hotels. Furthermore, any society with basic infrastructure for health care services will experience high costs of care for heart and lung disease that could have been prevented with public measures to reduce smoking among lower socioeconomic groups.

"Investment in health is essential for economic growth based on a productive workforce. To achieve this, growth must be accompanied by more equitable access to the benefits of development, as inequities have severe health consequences and pose an unacceptable threat to human well-being and security" (World Health Organization, 1995a).

Arguments for equity in health and in health care:

■ Ethical:

- Equity means fairness.
- Both health and health care are human rights.

■ Pragmatic (self-interest):

- Equity, along with effectiveness and efficiency, is a practical imperative.
- Disregard for equity is socially destabilizing.
- Disregard for health equity is incompatible with long-term productivity. No society can afford to discard its human capital.
- Disregard for equity in health and in health care jeopardizes the health of everyone because of spillover effects (crime, infectious disease, greater costs for treatment than for prevention).

Why focus on both health and health care?

Equity in health status and in health care must be considered separately. Equity in health status means the attainment *by all* of the highest possible level of physical, psychological and social well-being that biological limitations permit. Many biological limitations are amenable to modification; for example, most of the blindness in the world is avoidable or reversible with basic preventive and curative measures involving sanitation and health care.

Equity in health care means that health care resources are allocated according to need, health services are received according to need, and payment for health services is made according to ability to pay. Equity in health care implies a commitment to ensuring high standards of real (not only theoretical) access, quality and acceptability in health services for all. Real access requires active effort to remove a range of important obstacles – financial, geographical or physical, or other logistical barriers (e.g. conflicting family or work responsibilities); linguistic, cultural, or educational barriers; or a perception of low quality of the services – that prevent certain groups from receiving services available to others. Work is needed to develop practical methodologies for monitoring social gaps in the quantity, quality and financing of health care to assess the impact of health care reform in developing and industrialized countries.

Equity in health care means that health care resources are allocated equitably, health services are received equitably, and payment for health services is equitable.

Many factors apart from health services are powerful – often the most powerful – determinants of health status. Widening gaps in health status may be one of the most sensitive indicators of problems with broad economic or social policy; responses from the health care sector alone may not be effective or efficient. This initiative is therefore concerned not only with inequities in health care but with avoidable social inequalities in health status itself.

Social gaps in health indicate a need to reassess policies in many sectors in addition to health care.

The biggest threat to health equity is overall socioeconomic inequity. The powerful relationships between socioeconomic status and health have been demonstrated repeatedly. There is increasing evidence of a strong relationship between overall socioeconomic inequalities and poor health that cannot be explained by absolute levels of poverty.



Equitable allocation of health services is an important measure of equity in a society.
Photo: WHO/L. Taylor (21599)

Health services, however, while not the only determinant of health status, are an important factor. Furthermore, the degree to which a society provides an equitable allocation of health services is itself an important measure of equity in that society.

Examples of affordable interventions that have had a favourable impact on health, when combined with appropriate primary preventive measures, include the following:

- immunization
- prenatal and postnatal risk assessment and health promotion, including support for smoking cessation and breastfeeding
- obstetric services
- family planning services
- medical and dental services to relieve pain and suffering and limit disability
- timely surgery for appendicitis and other serious but common and curable conditions
- care for victims of trauma
- screening and treating women at elevated risk for cervical cancer
- early detection and treatment of tuberculosis
- improving quality of life for the elderly with simple measures to make it easier to be independent (such as providing walking sticks and support railings and removing environmental hazards)
- community-based supportive mental health services for people with mental illness and their families.

Part 3

The initiative for equity in health and health care

This initiative assumes that better information will support better policies that will result in more equity in health and health care, but only if the information obtained is valid and practically useful for decision-making in the specific context being considered; if there is sufficient commitment to act on the information; if both assessment and evidence-based action are sustained over time; and only if the health sector works closely with other sectors to achieve the desired outcomes. Activities are therefore needed in all of the following areas: policy-oriented research, policy-oriented ongoing monitoring, and informed policy development and implementation.

Objectives

The objectives of the WHO initiative for equity in health and health care are:

- to make the reduction of social gaps in health and health care a higher priority on the agendas for policy and action of national and international organizations, recognizing the pressures created by current economic, social and political trends;
- in selected countries, to support targeted research and ongoing monitoring activities needed to develop and evaluate effective and efficient policies to reduce social gaps in health and health care. The activities in selected countries should develop models and technical instruments that other countries may adapt for their own conditions;
- to promote and support international exchange of experiences that hold promise for being effective and efficient in reducing social gaps in health and health care.

Strategies under consideration

Policies and programmes for equity in health and health care: lessons and promising examples from Africa, the Americas, Asia and Europe

Economic growth does not automatically lead to more equity. Economic growth can create opportunities to achieve more equity, but only when there is a strong commitment to equity and a sustained series of actions towards that goal. Furthermore, equity in health development is possible even when growth is most constrained.

- ***With large-scale public efforts to increase opportunities for less privileged groups, economic growth can help create opportunities to achieve more equity.***

Malaysia and South Korea have experienced excellent and sustained economic growth as they have pursued policies designed to achieve more equity. The Republic of Korea (South Korea) has experienced substantial economic growth and has made major investments in education and health over the past three decades. A national health insurance programme begun during 1977 covers 94% of the population; the remainder are covered by a medical assistance programme. The government has provided financial incentives to the private sector to expand services in rural areas, and has launched an ambitious family planning programme. Life expectancy has improved by 20 years over the last three decades (United Nations Children's Fund, 1995).

The UNDP's most recent *Human development report* notes that Malaysia has had high economic growth rates since 1960, pursuing policies that have resulted in "rapid growth and human development . . . [that are] mutually reinforcing . . . in a continuous chain of cause and effect". Major government programmes emphasized support for education and other antipoverty measures (irrigation, land reclamation) for the rural poor; the Malay ethnic group, just over half the population, which had been economically far behind other ethnic groups, received targeted attention. Economic growth seemed to be enhanced for all groups as ethnic gaps diminished and social stability increased (United Nations Development Programme, 1996).

- ***However, economic growth does not automatically lead to more equity.***

There is increasing evidence of greater social inequality in a number of countries despite overall economic growth; examples include Brazil (Psacharopoulos et al., 1993; United Nations Development Programme, 1996a), Thailand (United Nations Development Programme, 1996a; Anon., 1996), Australia and the United States (United Nations Development Programme, 1990, 1991, 1992, 1996a). The UNDP report dis-

tinguishes between economic growth that does and does not lead to human development: human development requires equitable growth (United Nations Development Programme, 1996a). Equitable growth is not an automatic byproduct of economic growth.

Equity in health development is possible even when growth is constrained.

- Some of the most effective and efficient strategies for equity in health are outside the health care sector.
- Many interventions in the health sector can yield improvements at relatively low cost.
- Efficient strategies make the best use of available resources, but savings in greater efficiency are unlikely to be sufficient. Equitable financing methods must be sought. Donor support must reinforce, not undermine, equitable policies.

• *Equity in health development is possible even when growth is constrained.*

Some of the most effective and efficient strategies for equity in health are outside the health care sector. Rural credit schemes have been important; for example, a programme in five of the most disadvantaged areas of the Sudan relied on a traditional village fund to create seed money for local development projects (Jazairy, Alamgir & Panuccio, 1993) that are likely to have major health implications. Ensuring adequate income-generating capacity (e.g. in agriculture or crafts) among women has been particularly successful (World Bank, 1993).

Programmes promoting the education of women and girls have been shown to have very high yields in health status on a population-wide basis. Even as little as one to three years of schooling have been associated with increased use of prenatal care, appropriate obstetric delivery services and immunization; better hygiene and nutrition; later initiation of childbearing; increased benefit from health information and increased ability to alter damaging health behaviours (e.g. smoking, exposure to AIDS) as well as increased access to income (ibid.).

Sustained improvements in women's education, within the context of broad strategies to improve women's status and opportunities overall, appear to have been important components of success in reducing social inequalities in health in China, Costa Rica, India (the Kerala region) and Sri Lanka (ibid). Books and teaching materials can be provided at low cost, and efficient approaches can be used for training local teach-



Education of girls and women is associated with improved nutrition, decreased infant mortality and decreased fertility.

Photo: UNICEF/Laura Hess (95-0777)

ers. In an area of Chad, UNICEF has committed to providing incentives to families to defray the immediate financial losses involved in sending girls to school, an activity that takes them away from essential household tasks such as wood-gathering and child care (French, 1996).

Investment in “appropriate technology”, i.e. improving traditional technologies likely to be accessible and affordable, has greatly improved agricultural productivity, which can be one of the most important factors in nutritional status (Cornia, Jolly & Stewart, 1987). Examples include improvements in small-scale sugar processing in India and development of a stove designed for smoking fish in Ghana (ibid.).

Many interventions in the health sector can yield significant improvements at relatively low cost, especially when selectively targeted to the populations in greatest need. Components of the child survival programme promoted by UNICEF, including immunization and home oral rehydration therapy, have long shown health improvements at low cost. An essential drugs programme in Tanzania demonstrated that for roughly USD0.30 a person, it was possible to effectively provide 75% of the rural population with a regular supply of between 32 and 36 essential drugs and to train community health workers to prescribe medications more effectively (Cornia, Jolly & Stewart, 1987). An integrated child survival programme in Indonesia covered 8.9 million children under age five with health surveillance, oral rehydration therapy, breastfeeding promotion, immunizations, vitamin A supplements and nutrition education at a cost of USD6–7 per child (*ibid.*).

In Karachi, Pakistan, the Aga Khan University developed a series of community-based urban primary health care models, each serving about 10 000 people, relying heavily on community health workers. For USD2.32 per person per year, the project was associated with a reduction in infant mortality of up to 56% (from 170 to 75) in some areas and of 49% (from 126 to 64) overall; decreases in under-five mortality have been comparable. Immunization of children and pregnant women has increased substantially. An information system tracks up to 32 routine health indicators over time (Husein et al., 1993). Such small-scale experiments by nongovernmental organizations have shown what is possible; achieving large-scale and sustained change will require public commitment.

Efficient strategies are needed to make the best use of resources, but savings from greater efficiency are unlikely to be sufficient. Equitable financing methods must be sought, and donor support must reinforce equitable policies. Major savings can result from strengthening primary care services at the community level and ensuring adequate referral mechanisms to minimize use of costly hospital sites for simple problems better addressed elsewhere, but this requires careful planning and cannot be accomplished overnight. Segall has pointed out that “hospitals are not the ‘enemy’ of primary health care but an essential component of a [primary health care-] based system” (Segall, 1991). He notes that the rate of increase of hospital expenditures can be slowed, but that outright cuts in hospital budgets are probably unrealistic in many circumstances.

Inadequate funding of public services is a major cause of inefficiency. For example, deteriorated buildings and equipment cease to function; inadequate wages for health workers lead to low morale and more “moonlighting”; “patient care and health programs [often] founder for lack of drugs, supplies, transport, supervision, and support services” (*ibid.*).

An earlier section of this document discussed evidence that cost recovery within the health sector may be inherently inequitable as well as inefficient; health and other essential social services must be sustained by progressive, general taxation.

- Progress towards equity requires changes in the way resources are allocated to different social groups.
- Some countries have been able to counterbalance the strong tendency to allocate more to those who already have more.
- Identifying and reaching those in greater need requires conscious, focused effort.

- *Progress towards equity requires changes in the way resources are allocated to different social groups.*

Allocating resources more equitably. The tendency everywhere is for resources to be allocated to those population groups who have greater political influence. Birdsall and Hecht have stated that "to implement policies that favor the poor, it is necessary to 'swim against the tide'"; the tide represents the direction of the prevailing forces (Birdsall & Hecht, 1995).

Some countries however, such as Costa Rica and Malaysia, have been able to counterbalance this tendency to allocate more to those who already have more. In Costa Rica in 1988, 30% of government spending on health went to the poorest 20% of households, compared with just over 10% for the wealthiest 20% of households; this reflected priorities in sectors in addition to health care.

Similarly, since the 1970s the Malaysian government has allocated more public subsidies to the lowest-income groups rather than to the middle class and wealthy (World Bank, 1993). In Costa Rica, life expectancy improved by eight years in one decade, largely as a result of improved infant mortality. In Malaysia, life expectancy improved from 58.2 years at independence (1957) to 71 in 1993 (United Nations Children's Fund, 1995).

Identifying and reaching those in greater need requires conscious, focused effort. Better information can help target resources to the pockets of greatest need. In Brazil, researchers with public and NGO support developed a Geographical Information System (GIS) as part of an effort to decentralize health services. A project was undertaken in the Pau da Lima district of the city of Salvador.

The Pau da Lima district, with very heterogeneous conditions, had undergone a rapid population increase. All of the district's nine health centres (five state, three municipal, one NGO) used different data collection forms. While averaged data were available for the district, they oversimplified the complexity of needs. The goal of the project was the creation of a new management system that would generate useful data for local planning, implementing, monitoring and evaluating district health services.

During the first stage, the data collected included official statistics and informal data based on brief surveys and observations. Differences within zones served by health centres were found to be larger than between zones within the district. Research showed officials that access was especially difficult for people from a number of zones and the type and quality of services offered at a site strongly influenced demand.

After the sample surveys, a new procedure to collect primary data was implemented, with simplified, uniform data forms and computerization. Large health centre areas were divided into smaller areas of 1000 to 1500 inhabitants that could be distinguished from each other on important characteristics and were fairly similar on key characteristics within their boundaries.

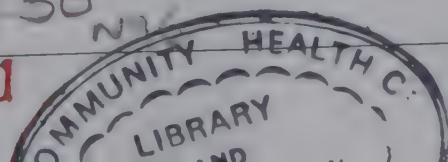
Early information indicated that a particular subgroup had particularly poor access to health care services, due not only to long waits and limited hours at clinics, but also to lack of awareness that many common conditions could be improved with treatment. One result was the decision to train community health workers (CHWs) to reach that subgroup (de Kadt & Tasca, 1993).

- ***A real commitment to equity requires long-term capacity-building, not just short-term acts of charity.***

Successful experiences with promoting equity in health and health care have addressed root causes of social deprivation, not just their symptoms. Actions in the areas of income and employment generation, education, nutrition, sanitation, improving women's status and strengthening local organizations have been prominent. Successful approaches to achieving equity in health development have been part of a broader social development strategy; the following are some examples.

Rural credit. The provision of credit to people in rural areas has been among the most promising approaches to achieving greater equity both efficiently and effectively in recent years. The nongovernmental Grameen Bank in Bangladesh provides credit to small voluntary groups (about five members) of people who mutually guarantee loan repayment. More than 90% of borrowers are women, repayment rates are now at 97%, and the borrowers have been able to successfully save 25% of the income gen-

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erated. The programme has succeeded in improving household income, in shifting employment from rural agriculture to self-employment and small-scale trading, in improving the nutritional status of children, in alleviating poverty and in improving women's status and independence (Jazairy, Alamgir & Panuccio, 1993).

The Grameen Bank experience in Bangladesh has been used as a model for successful experiences elsewhere, e.g. in Malawi (Cornia, Jolly & Stewart, 1987). Sri Lanka's "Janasaviya" (*people's power*) poverty alleviation programme emphasized rural credit to begin small-scale enterprises (United Nations Children's Fund, 1995; World Health Organization Regional Office for South-East Asia, 1993).

Improving women's status. A village-based nutrition programme in Burkina Faso has trained village women to detect early signs of malnutrition in their children during times of food shortages and to seek advice and supplements available from local health services. This programme has also included community-wide nutrition education activities promoted by the village women, and providing access to labour-saving devices for food processing (Gellen, 1993).

Strengthening local organizations. In 1991, Peru initiated a public/NGO fund for social compensation and development called FONCODES that provided grants for communities that wanted social assistance and infrastructure projects and loans for small enterprises. Local groups criticized FONCODES and proposed a more participatory alternative called PREDES. When PREDES was implemented, district development committees composed of local government and nongovernmental groups met regularly to identify needs, formulate specific projects and reassess long-term development goals.

PREDES seems to have succeeded in devoting greater resources to development activities, reaching the poorest members of a community, improving the sustainability and quality of development by having more local oversight and control, and using interagency cooperation to link social assistance to long-term development (Jazairy, Alamgir & Panuccio, 1993). One source criticized PREDES for over-reliance on NGOs (rather than public organizations) because of inadequate funding, but the same source noted:

FONCODES tried to demonstrate that it was more efficient and that its funds went directly to the population. PREDES, on the other hand, tried to strengthen local organizations and municipal governments through a complex process of consultation and consensus-building. FONCODES approved projects more rapidly but they were often of poor quality. PREDES is a slower process, but the projects are more likely to be sustainable (Burt, 1996).

Information for action

- Useful facts and figures already exist in most countries, but are underused.
- Data on health and health care must be broken down according to social groups, in order to make comparisons and assess how gaps change over time.
- Simple, familiar indicators of health status and health care can be used; at least a few different measures should be assessed.
- Both the absolute levels (of health and health care) and the gaps must be measured.
- Both research and ongoing monitoring are needed.
- The goal of information is to support better policies; this won't happen unless the policy implications of facts and figures are discussed clearly.

- *Useful facts and figures already exist in most countries, particularly from census departments, but are often not examined.*

Government ministries often have a wealth of unexamined data. Useful data from national household surveys, including both economic and health data, are likely to be found in census departments, central statistical offices and finance labour ministries.

For example, the *Demographic and health surveys* (DHS) are large, population-based, national household surveys on maternal and child health. The DHS have been conducted over the past ten years in 54 developing countries by local census departments or nongovernmental organizations with support from local funds and the U.S. Agency for International Development. The DHS have been conducted at least twice in more than 20 countries, and three times in seven countries (permitting examination of time trends).

The technical quality of the DHS is generally high; samples (2000 to 30 000) are large enough to make national and subnational estimates. The DHS include a rich array of questions on socioeconomic status as well as measures of urban/rural residence, age, ethnicity and religion, and gender, along with a broad range of indicators of health status and health care for women and children.

Although the DHS have primarily been used to look at family planning issues, they could be valuable for assessing social patterns and trends in maternal and child health and health care over time. In many countries, other national household surveys and censuses often cover relevant issues in addition to maternal and child health, including measures of nutritional status and functional levels across the age spectrum. Lack of timeliness in gaining access to the information may be a limitation of some surveys, however.

Many United Nations agencies and nongovernmental groups also collect routine statistics and descriptive information as an ongoing part of their projects. One ministry or department may not be aware of data that exist in another office nearby.

For example, evidence of a severe economic recession began emerging in Ghana during the early 1980s and the ministry of health lacked hard data to know whether there were health effects; the most recent national nutrition survey had been completed in 1961, and the most recent estimates of infant mortality were from the late 1970s. However, Catholic Relief Services had been collecting nutritional data as a part of an ongoing feeding programme. Other information on utilization and health status was also available from small local studies and from other ministries. Together, the combined information demonstrated that the recession was having significant health effects (Cornia, Jolly & Stewart, 1987).

It is important to keep in mind, however, that already existing data were not designed for the purpose of monitoring equity and have many limitations for this purpose. New research and improved monitoring methods are needed.

- ***Data must be broken down according to differences in socioeconomic status, geographical location, gender, race or ethnic group and age, which reflect differences in social advantage virtually everywhere.***

Data must be disaggregated (broken down) to reflect what is happening in different social groups. Socioeconomic and small geographical differences often coincide. A distinction between urban and rural alone is no longer sufficient in almost any country, because of tremendous differences in disadvantages for people living in urban slums compared with other urban areas. Sources of data are needed that include indicators characterizing the key factors that reflect social advantages and disadvantages, and that permit disaggregating data on health and health care according to these factors.

Data on age, urban-versus-rural residence, gender and racial/ethnic group are easier to come by than information on socioeconomic status. Conclusions about policies and programmes can be mistaken if information on socioeconomic differences is lacking.



Socioeconomic differences often coincide with small differences in geography.

Photo: UNICEF/A. Graciano (3721/90)

For example, issues can be falsely interpreted to be simply racial or ethnic when the real issues are primarily socioeconomic or a combination of both, and purely race- or ethnic-focused approaches would be ineffective. The lack of routine information on socioeconomic status in health data in the USA has often resulted in attributing many health disparities to racial or race/ethnic-tied "cultural" factors that are implicitly or explicitly viewed as intractable. With insufficient evidence to justify such interpretations, racism can unwittingly be reinforced. Promoting and supporting the incorporation of practical information on socioeconomic status into routine health data in all countries is an important long-term goal of this initiative.

Routine health sector statistics generally lack direct information on socioeconomic status. However, better use could be made of some existing health care data sources. Because both socioeconomic status and environmental hazards vary according to where people live, breaking health and health care data down on maps (manually or by computer) can be a powerful tool; the breakdowns must be in fairly small geographical areas, however, to capture the real boundaries that define socioeconomic or environmental disadvantage (see de Kadt & Tasca, 1993, on geographical information sys-

tems). An address or postal code or neighbourhood or village name can be used along with census information on socioeconomic and environmental conditions in each small area.

The Ministry of Health Services in Nepal has produced an *Atlas of population distribution and health facilities*. The atlas includes maps and district profiles for each of the 75 districts in Nepal and includes national, regional and disaggregated district-level demographic information and information on literacy, environmental health, maternal and child health and family planning (Nepal, Ministry of Health Services, & United Nations Population Fund, 1995). These data are available in a way that can be interpreted and used in health planning at multiple levels.

- ***Simple, familiar indicators of health status and health care can be used, rather than complex indices.***

At least a few different indicators should be used, to see if conclusions vary depending on the measure used. Use of a range of simple indicators can help compensate for the limitations of using any single indicator. Results from using simple indicators may be confirmed from time to time by special research efforts employing complex indicators.

Simple, familiar indicators of health status that are useful include (but are not limited to): low birth weight; malnutrition in children under five; neonatal, post-neonatal/infant and child mortality; maternal mortality; premature mortality; life expectancy at birth.

Simple, familiar indicators of health care that are useful include (but are not limited to): the proportion of all two-year-olds and pregnant women with appropriate immunizations; the proportion of pregnant women receiving timely prenatal care; the proportion of deliveries with a trained attendant present; the number of previous births to women who give birth (or another indicator of fertility rates); the proportion of women of childbearing age desiring family planning services who are receiving them.

- ***Both the absolute levels and the gaps in health and health care must be measured.***

Gaps must be reduced by bringing people up to better levels, with faster improvements for the formerly most deprived groups – not by lowering the health status of formerly favoured groups. Therefore, when monitoring equity it is important to in-

clude measures of absolute well-being and the proportions and numbers of the population whose needs are being met, as well as measures of the size of gaps between different social groups.

- ***Both research and ongoing monitoring are needed.***

A research effort may be a one-time investigation to answer a very specific question. Monitoring, on the other hand, involves repeated assessments over time, usually with more broad information-gathering purposes. Because monitoring is ongoing, it requires methods that can be reliably reproduced at different times and under different circumstances, and hence methods that are affordable for an ongoing effort.

Some questions don't need to be investigated over and over again, unless a particular concern arises that calls into question the validity of previous knowledge. The issues that require monitoring are those likely to change over time – for example, how well different social groups are doing with respect to their health and health care, in absolute terms and in relation to each other.

Monitoring generally requires simpler methods than one-time research, but must be technically sound and should be informed by methodological knowledge gained from sound research. Results from monitoring activities should be periodically verified by comparisons with results obtained using more sophisticated techniques.

Monitoring will generally detect only broad trends, without providing explanations or showing how to reduce inequities. In addition to ongoing monitoring, focused research on specific questions is also needed. Both qualitative and quantitative investigation are needed and require collaboration among researchers in social, behavioural and political sciences and economics as well as biomedical sciences.

Research is needed on how different societies view equity as a value, and to investigate the connection between particular policies and health equity. The ultimate goal of such research should be to identify the most effective and efficient actions for reducing social gaps in health and health care.

- ***The goal of information is to support better policies; this won't happen unless the facts and figures are presented in a way that will generate discussion among the public and policy-makers.***

The public as well as policy-makers must examine the implications of facts and figures for overall economic and social policies as well as health care policies. Comparisons between groups and over time are critical. The information must be not only scientifically sound but simply and attractively presented to the public, professional groups and decision-makers in health and other sectors in the participating countries and to relevant donor agencies.

A message put together for one audience will not necessarily be informative for another. For example, materials that are very informative for researchers and technical audiences may have little value for nontechnical audiences, including very educated but busy policy-makers who don't deal frequently with technical data issues. Presentation on maps is particularly effective for drawing attention to inequalities in a way that suggests possibilities for action in the places where it is most needed.

(Real) information versus "data": Facts and numbers must be interpreted in relation to policies likely to affect health and health care.

From information to action

From information to action:

- Public attention and consensus must be mobilized to ensure political will for action. Information alone is not enough.
- Real changes are needed in resource allocation.
- The best technical efforts are needed, not just good intentions.
- Health services alone won't suffice.

- *Information alone is not enough: it is important to get the message out, in order to mobilize public attention and achieve public consensus to ensure political will. There must be strategic thinking about political obstacles.*

A casual search for information on equity reveals that while there are many limitations of existing information, considerable information already exists but has not been used as effectively as needed. Getting from information to action is a challenge that requires as much attention as ensuring the scientific quality of the information. Those concerned about equity must be persuaded that information alone will not result in informed action, and must become more effective at influencing the policy process.

Technical and political aspects of developing and implementing policies need equal attention. "If the technical side is neglected, bad policies get implemented – if the political side is neglected, good policies fail to get implemented (Sandiford, 1996). Without a practical strategy for putting equity higher up on the policy agenda, the most solid information will not result in action. Obstacles are particularly great when public sector resource constraints are most severe.



Public attention and consensus must be mobilized to ensure political will for action; information alone is not enough. Photo: UNICEF/Ray Witlin (1602/86)

Getting the message out: The strategic use of information can capture public attention
Madhya Pradesh, a region in India, recently issued a district-level human development report based on a “human development index” composed of familiar measures of health, education and income. The report was distributed to the press and to officials in governmental and nongovernmental agencies.

Many of the findings were significantly worse than the national average for India. For example, the region’s infant mortality rate of 106 per 1000 live births was higher than the rate of 81 for India as a whole, and the literacy rate of 43% compared poorly with a national average of 52%.

The report relied almost entirely on a pre-existing state government household survey conducted in 1991–1992, except that information on income had to be collected through a special effort. The regional government hopes the report will motivate social action to improve resource allocation to poorer districts, help stimulate the design of creative area-specific projects (e.g. training of barefoot doctors) and promote international assistance to the region (Jishnu, 1995–1996).

The need for consensus. Experience in European countries that have tried to focus on equity has shown that even when data are plentiful and clear, public consensus on the issues and social values must be clarified in order to ensure the political will to follow through with difficult choices.

Notions of what is equitable vary; a campaign for more equity in health will need to appeal to the public's sense of fairness according to that society's standards. This will require a process of discussion that acknowledges and addresses existing disagreements about what is fair.

Similarly, broad consensus is needed on the best ways to achieve more equity, once the problem is acknowledged and commitment to address it is made explicit. Diverse segments of the public, professionals in the social and economic sectors and decision-makers must be engaged in discussing the meaning of social gaps in health and health care and in formulating recommendations for better development policies that are perceived as benefiting everyone.

Political obstacles must be addressed strategically. Political obstacles can include privileged groups such as more affluent people, employed people who are already insured through their employment, and city dwellers; health workers, especially the most highly trained health workers, can resist redistribution of resources towards less specialized services and away from urban centres where they prefer to live. When redistribution of resources is necessary, it sometimes may be politically feasible only to slow the rate of growth of over-funded services such as urban hospitals, rather than execute outright cuts likely to lead to very strong reaction and backlash (Segall, 1991).

Private health insurance companies can have a lot to gain or lose from "reform" proposals, as can private companies that manufacture or distribute drugs or medical supplies. Politicians and officials are accountable to their electoral constituencies and financial backers. Bureaucratic inertia can be a powerful obstruction in itself (ibid.). Forces that contributed to the success or failure of previous attempts at change must be analysed.

Medium-term (two to five years) and long-term (five to ten years or longer) objectives must be considered, as well as likely short-term effects; planning must put tactical adaptations into an overall strategic framework. Information is needed to monitor progress towards targets.

Under WHO regional leadership, European countries have set general targets for reducing gaps in health status during defined time periods; setting targets and monitoring progress towards their achievement can be useful in keeping an issue on the agenda. Sandiford has defined the "agenda" as "the list of subjects or problems to which gov-

ernment officials are paying serious attention” and has commented that “The agenda is important because people have a rather limited capacity to seriously deal with many issues at once. Hence, getting things on the agenda is an important part of policy formation.” (Sandiford, 1996).

- ***Achieving equity requires real changes in resource allocation; targets for equitable services and outcomes won't suffice.***

Many countries spend a disproportionate share of their health budgets on hospital and tertiary-level care. For example, during 1986 Bangladesh spent 80% of its budget for recurrent public health on hospital care; in Brazil during 1982, 70% of public health funds went for physician and hospital care, much of which involved expensive high-technology procedures (Birdsall & James, 1993).

In contrast, relatively little public health money goes to proven cost-effective measures such as maternal and child health and improved sanitation. Middle- and upper-income groups with greater political power often demand and make greater use of such services. In a similar manner, higher-income groups are more likely to benefit from government educational expenditures favouring higher education (ibid.).



Relatively little public money goes to proven cost-effective measures such as maternal and child health and improved sanitation. Photo: UNICEF/Giacomo Pirozzi (92-0087)

Inequitable resource allocation can lead to a vicious cycle in which investing more in populations who already have more may seem more efficient in the short run, because traditionally deprived populations may require a larger initial investment to create genuine opportunities. Facilities whose maintenance has been neglected for a long time, and personnel whose training and supervision have been neglected, may require more investment to become productive in the short term, compared with facilities and personnel for whom capital and recurrent expenditures have been greater. Services perceived to be of low quality will be underused. Extensive work has been done in the United Kingdom to develop and use equity-conscious geographical resource allocation formulae for the British National Health Service (Department of Health and Social Security, 1976; National Health Service Management Board, 1988; Carr-Hill et al., 1994a; Carr-Hill et al., 1994b; Smith P et al., 1994; Mays, 1995).

- ***Good intentions aren't enough: The best technical efforts must be mobilized in designing, planning, implementing and evaluating changes.***

Given the strong pressures worldwide to contain costs for public and private services, it is not enough to proclaim loudly and widely that equity is a moral imperative. Throughout the world, in situations where there is a strong social commitment to equity, decision-makers need practical help in choosing the best, locally appropriate strategies and tactics that will lead to equity, effectiveness and efficiency.

Practical approaches are needed for policy-oriented information-gathering; getting the information out to the public and policy-makers in all the sectors that influence health, in ways that will mobilize political will; using the information to develop more equitable, effective and efficient actions; and ensuring ongoing monitoring and reassessment of policies and programmes in relation to goals and experience.

- ***Health services alone will not suffice: Intersectoral action is needed to achieve equity in health development.***

Health care services are important but by themselves will not have sufficient impact to reduce health inequities. Experience throughout the world has demonstrated that education, housing, employment, nutritional supply and transportation have profound effects on health and on health care, and that joint planning and resource-sharing among the different administrative sectors in charge of these different areas are needed for effective and efficient action.

Widespread belief among health professionals and the public that medical care is the panacea for all problems can stifle opportunities to focus on more effective interventions. Health workers and others truly interested in improving health status must look beyond as well as within the health sector.

Activities now under way or planned. The need for additional support and linking with other efforts

Country-based activities now under way

With funding from the Swedish International Development Cooperation Agency (SIDA), country-based activities under local leadership are now under way in one country in Africa and one in Asia, along with plans for efficient ways to expand efforts in those and other continents via WHO regional offices, if additional support can be identified. These initial experiences are intended to serve as models for subsequent efforts in many countries, with the understanding that work in each country must be individualized to that setting.

Country-specific reports will use existing data to:

- describe patterns and trends in social gaps in health and health care over time;
- begin to critically assess plausible relationships between those patterns and trends and policies (general economic and social as well as health care policies);
- based on the critical assessment and a wide process of discussion, develop recommendations for the highest priorities in policy development, research and ongoing monitoring to achieve and maintain greater equity in health and health care most effectively and efficiently.

The reports are vehicles to stimulate a process of public discussion and policy development, not ends in themselves. Mechanisms for discussion and dissemination of the reports include:

- public media briefings, public forums, town meetings using existing public & private organizational structures for public discussion;
- conferences, special forums or meetings, and publications by professional groups from the range of sectors concerned with health-related policies, research and monitoring;
- forums and briefings for policy-makers in the social sector (including but not limited to health) and economic sector at local, provincial and national levels.

Each participating country will produce and widely disseminate a report examining its patterns and trends in social inequalities in health and health care in relation to policy in health care and other sectors. The report will describe disparities among socioeconomic, geographical, gender, age and ethnic groups, in measures of health status (including measures of well-being as well as disease) and health care (including measures of resource allocation and of use and financing of health services), and how the disparities appear to have changed over time. Overall economic, social and political trends likely to affect public health and major influences on health care will be described for the relevant time periods.

National teams led by independent researchers including social scientists and policy analysts, collaborating with policy-makers, will begin the process of interpreting what the trends in disparities in health and health care may mean in relation to major changes in health and macroeconomic/social policies or conditions. Trends will be examined as far back as available data permit, but over at least 20 years. Plausible relationships between trends in health equity and major policies will be discussed, with recommendations for the highest priorities in policy development, research and ongoing monitoring.

The country reports are vehicles to generate a process of critical analysis and discussion, rather than an end in themselves. They will rely on creative and scientifically rigorous re-analysis of existing data; and will emphasize effective presentation in attractive, nontechnical formats designed for the public and policy-makers.

Interim as well as final reports will be discussed widely with the public, professional groups and policy-makers, to obtain critical input and stimulate wide awareness. Existing multisectoral mechanisms for discussion will be used, including national, provincial/state and local development councils, as well as professional groups (in health, education and other social sectors) and nongovernmental community groups.

The need for additional support and linkages to expand the initiative to other countries, for intercountry exchange and other international activities to promote and support equity in health and in health care

Expanding the initiative to include additional countries. Country-specific activities must be shaped by local needs. Extensive discussion has indicated that the objectives and types of activities being launched could be generally responsive to interests in many developing and industrialized countries with appropriate country-specific modifications. Both governmental and nongovernmental institutions will participate.

WHO's Health Systems Development Programme could provide a mechanism for working with WHO regional offices to involve many more countries in locally appro-

priate activities. Through WHO's Regional Office for Europe (EURO), countries of eastern and central Europe could be included. The WHO Joint Project for Health Services Research in Southern and Eastern Africa, now involved in supporting the initial country work, has expressed interest in the inclusion of a number of countries of that region.

The WHO Regional Office for the Americas/Pan American Sanitary Bureau (PAHO/AMRO) hopes to launch country-specific work on this initiative in at least two countries of Latin America and the Caribbean; additional resources are needed to support this adequately and to include more countries of the Americas. WHO's Regional Office for South-East Asia (SEARO) also has focused on regional concerns regarding equity, and has expressed interest in participating in the expansion of this initiative in the Southeast Asia Region. Similar possibilities exist through the other WHO regional offices but also require funds for country-specific work.

Intercountry exchange. Another sphere of desired activity is promoting and creating forums for intercountry exchange of experience and promising strategies in developing policies to reduce social inequalities in health and health care. Exchange is sought between industrialized and developing countries as well as between industrialized countries and between developing countries.

Particular interest has been expressed in having opportunities for exchange of experiences and strategies most likely to be effective under conditions of severe resource constraints. A small working session was held in Geneva in December of 1995 with participants from all continents. Resources are needed to support ongoing exchange among participants from different countries, including countries whose participation is channelled from within or outside WHO structures.

The initiative will promote and support exchange among policy-makers and researchers in different countries, to share experiences and strategies.

Expanding worldwide Global activities involve promoting increased attention to the issue of equity internationally and encouraging and participating in collaborative interagency efforts to achieve common goals. Wide discussion of the issue of equity in other international organizations and forums is sought, along with linkages among related efforts by nongovernmental organizations and United Nations-system agencies. Strong continued support for this initiative is expected from WHO and from SIDA; despite this commitment, additional resources will be critical.

The initiative aims to promote increased focus on equity in health and health care in WHO and other international organizations. Donor actions must reinforce more equitable policies.

Final comments. The WHO/SIDA Initiative for Equity in Health and Health Care builds on work towards health for all by WHO and others over the past three decades, and responds to concerns shared by other United Nations agencies, including UNDP and UNICEF. This new initiative is based on a critical reassessment of needs and strategies in light of current economic, social and political conditions prevailing throughout the world as we approach the year 2000.

WHO and the Swedish International Development Cooperation Agency have funded initial planning and development; previous efforts by WHO in Western Europe and other regions have provided a foundation. Projects are now under way in one country in Africa and one in Asia, directed and conducted by domestic governmental and nongovernmental organizations with technical assistance from WHO.

Additional sources of support are needed to expand and further develop the initiative. Support is being sought to include other developing and industrialized countries; for exchange among countries; and to promote more discussion and practical work on equity within international organizations.

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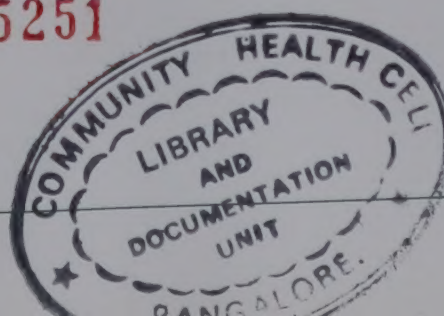
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Social gaps in health and in health care are unacceptably wide and are widening throughout the world. Developing countries and industrialized countries alike are finding it difficult to implement equitable policies and often feel caught between considerations of equity and short-term efficiency.

This document describes an initiative of the World Health Organization, with seed funds from the Swedish International Development Cooperation Agency, to place equity in health and health care higher on the public policy agenda and to evaluate and promulgate promising practical approaches to achieving equity in health development.

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